OLR Bill Analysis

sHB 6323

AN ACT MAKING CONFORMING CHANGES TO THE INSURANCE STATUTES PURSUANT TO THE FEDERAL PATIENT PROTECTION AND AFFORDABLE CARE ACT, AND ESTABLISHING A STATE HEALTH PARTNERSHIP PROGRAM.

SUMMARY:

This bill establishes the Connecticut Health Partnership Exchange, a quasi-public agency, to satisfy requirements of the federal Patient Protection and Affordable Care Act ("PPACA") (§§ 12-24). Under the bill, an 11-member board of directors manages the exchange, including operating an online marketplace where individuals and small employers can compare and purchase health insurance plans that meet federal requirements beginning in 2014.

The bill also changes various health insurance statutes to conform with the PPACA (§§ 1-10). The changes relate to covering dependent children under health care policies until age 26, not denying coverage to children under age 19 because of a preexisting condition, eliminating lifetime maximums, prohibiting rescissions except in cases of fraud and intentional material misrepresentation, and the definition of medical loss ratio.

Lastly, the bill enables the Insurance Department to enforce PPACA provisions against entities it regulates, including insurers and HMOs. It authorizes the commissioner to adopt regulations (§ 11).

EFFECTIVE DATE: Upon passage, except for the provision redefining "medical loss ratio," which is effective January 1, 2012.

§§ 12-24 – CONNECTICUT HEALTH PARTNERSHIP EXCHANGE

Exchange Creation (§§ 14, 21-24)

The bill creates the Connecticut Health Partnership Exchange (exchange) as a quasi-public agency and subjects it to the statutes

governing such agencies. Public funds may be spent to carry out its purposes (see Purposes and Duties below). The exchange is not a state department, institution, or agency.

Under the bill, the exchange will continue as long as it has legal authority to exist and until its existence is terminated by law. Upon the exchange's termination, all its rights and properties pass to and are vested in the state of Connecticut.

Board of Directors (§ 14)

Under the bill, the exchange is managed by an 11-member board of directors. The board must annually elect a chairperson and vice-chairperson from among its members. Board members are not compensated, but are reimbursed for their expenses incurred in performing official duties. Board members are:

1. the social services commissioner or designee;

2. six directors, two each appointed by the governor, Senate president pro tempore, and House speaker; and

3. four directors, one each appointed by the Senate and House majority and minority leaders.

Directors must be appointed by September 1, 2011. Appointed members cannot designate anyone to act in their place.

Board Members' Terms and Meetings. Initial terms of the appointed directors are three years, except for the governor's appointees, who serve four years. Subsequent terms are all for four years, beginning on September 1 of the year appointed. Directors may be reappointed. Vacancies must be filled by the appointing authority for the rest of the term. If an appointing authority does not make an appointment initially or within 90 days of a vacancy, the board must make an appointment by majority vote.

Meetings must be held as specified in the bylaws the board adopts and at other times the chairperson deems necessary. Six directors

constitute a quorum to transact business. The board may establish committees, including a finance committee.

Any appointed director who fails to attend three consecutive meetings or 50% of all meetings during a calendar year is deemed to have resigned. The appointing authority may remove members for misfeasance, malfeasance, or willful neglect of duty.

Qualifications. Each appointee must have demonstrated expertise in at least two of the following areas:

1. individual health insurance coverage,
2. small employer health insurance coverage,
3. health benefits plan administration,
4. health care finance,
5. public or private health care delivery system administration, or
6. health insurance plan purchase.

The appointing authority must consider the other appointees' expertise when making an appointment to ensure the board reflects (1) a diversity of expertise and (2) the state's cultural, ethnic, and geographical communities.

Appointees and staff cannot be employed by, consultant to, or affiliated with (1) an insurer, insurance producer or broker, health care provider, health care facility, or health or medical clinic while serving in their positions or (2) a trade association of insurers, insurance producers or brokers, health care providers, health care facilities, or health or medical clinics. Appointees and staff cannot be health care providers unless they receive no compensation as providers and do not have an ownership interest in a professional health care practice.

As a condition of qualifying for the board of directors, an appointee must take the state Constitution oath or affirmation. A record of the oath must be filed in the Secretary of the State's Office.

Surety Bond. The bill requires (1) each director to execute a $50,000 surety bond or (2) the chairperson to execute a blanket position bond covering each director and employee of the exchange. Each bond must be (1) conditioned on the faithful performance of duties, (2) written by a surety company authorized to transact business in the state, (3) approved by the attorney general, and (4) filed with the secretary of the state. The exchange must pay the cost of each bond.

Written Procedures. The board must adopt written procedures in accordance with quasi-public agency law, which requires published notice before action, for:

1. adopting an annual budget and plan of operations, including a requirement for board approval before the budget or plan may take effect;

2. hiring, dismissing, promoting, and compensating employees of the exchange, including an affirmative action policy and a requirement for board approval before a position may be created or a vacancy filled;

3. acquiring real and personal property and personal services, including a requirement that the board approve any nonbudgeted expenditure over $5,000;

4. contracting for financial, legal, and other professional services, including a requirement that the exchange solicit proposals at least once every three years for each service it uses; and

5. the use of surplus funds to the extent authorized under the bill or law.

Required Hiring. The bill requires the chairperson, in consultation with the board, to hire an executive director, chief operations officer, chief technology and information officer, health plan contracting director, general counsel, and other key executive positions the board determines necessary. The applicants cannot be board members. Each is exempt from classified service.

Except for the executive director, the bill requires the board to set salaries that will attract and retain people with superior qualifications for each position. The board must publish the salaries in its annual budget, which must be posted on the exchange's website. In determining the salaries, the board must use independent outside advisers to conduct salary surveys of comparable health insurance exchanges and relevant labor pools. The board cannot pay more than the highest comparable salary for a similar position as determined by the survey. The bill requires the Department of Administrative Services to review the survey methodology.

The executive director serves at the board's pleasure and is paid the amount the board sets. The executive director supervises the exchange's administrative affairs and technical activities in accordance with the board's directives.

Freedom of Information. The exchange is subject to the Freedom of Information Act, except the following information is not subject to disclosure:

1. the names and applications of individuals and employers seeking coverage through the exchange;

2. individuals' health information; and

3. information exchanged between the exchange and the departments of Social Services, Public Health, and Revenue Services; the Insurance Department; the comptroller; or any other state agency that is subject to confidentiality agreements under contracts entered into pursuant to the bill.

Purposes and Duties (§ 15)

The purposes of the exchange include reducing the number of people without health insurance in the state and assisting small employers with purchasing and administering health insurance.

Authorized Actions. Under the bill, the exchange can:

1. establish a state office;

2. adopt by-laws and an official seal;

3. employ assistants, agents, and other employees and engage consultants, actuaries, attorneys, and appraisers as necessary;

4. enter into contracts or agreements for the following services: premium billing and collection, enrollment, data processing, and customer relations management;

5. enter into contracts or agreements with any state agency;

6. solicit, receive, and accept aid, grants, or contributions from any source;

7. borrow money to obtain working capital;

8. acquire, own, manage, hold, and dispose of real and personal property and lease, convey, deal, or enter into agreements concerning such property on any terms necessary to carry out these purposes, except acquisitions of real property that use state-appropriated funds or bond proceeds backed by the state's full faith and credit are subject to the Office of Policy and Management (OPM) secretary's approval;

9. obtain insurance against loss concerning its property and other assets;

10. sue, be sued, implead, and be impleaded;

11. account for and audit exchange funds and any recipients of exchange funds;

12. commission surveys of consumers, employers, and health care providers on issues related to health care and health care coverage;

13. facilitate the purchase of qualified health plans by individuals and small employers on and after January 1, 2014;

14. assess insurers or charge insurers user fees by January 1, 2015 to fund the exchange's administration costs;

15. limit the number of plans offered through the exchange using selective criteria, so long as customers have an adequate selection of plans; and

16. do all acts necessary and convenient to carry out its purposes.

Required Actions. The exchange must:

1. comply with the bill, PPACA, and related federal regulations and guidance;

2. apply for federal exchange planning and establishment grants;

3. make qualified health plans available to qualified individuals and employers by January 1, 2014;

4. rate each qualified plan and determine the level of coverage for each in accordance with federal law;

5. determine eligibility for premium tax credits, cost-sharing reductions, and mandatory insurance exemptions;

6. credit the amount of any "free-choice voucher" to the monthly premium for a qualified employee and collect the amount credited from the employee's employer (see below);

7. not charge an individual a fee or penalty for terminating coverage if the individual enrolls in another type of minimum essential coverage because (a) the individual has become newly eligible for that coverage or (b) the individual's employer-sponsored coverage has become affordable under the standards of the PPACA;

8. offer individuals and small employers the option of having the exchange collect and administer premiums;

9. establish procedures by which individuals and small employers

can buy an exchange plan through an insurance producer or broker; and

10. collaborate, if possible, with the Department of Social Services to allow an individual to stay enrolled in his or her plan and provider network if he or she loses premium tax credit eligibility and becomes eligible for Medicaid.

(Under PPACA, employers must offer certain employees a "free choice voucher." The employee can use the voucher to purchase a qualified health plan on the exchange.)

Report on Adverse Selection. The exchange must report at least annually to the legislature on (1) the effect of adverse selection on the exchange and (2) any necessary legislative recommendations to reduce the negative effect of any adverse selection. The report must include recommendations to ensure that regulation of insurers and health benefit plans are similar for qualified health plans offered through the exchange and health benefit plans offered outside the exchange. The exchange must evaluate whether adverse selection is occurring with respect to health benefit plans that are grandfathered under the PPACA, self-insured plans, plans sold through the exchange, and plans sold outside the exchange.

Regulation. The bill specifies that the exchange and its employees are not subject to regulation under Title 38a, the insurance statutes. (Thus, the exchange is not regulated as an insurance company.)

Consumer Focus of Exchange (§ 16)

Under the bill, the exchange must be administered in a way that focuses on individual and small employer needs. It must:

1. provide easily comparable, accurate, and objective information about qualified health plans it offers;

2. help individuals and small employers select and purchase qualified health plans through an Internet website, a toll-free hotline, publications, in-person consultations, and presentations;

and

3. award "navigator" grants (see below).

The exchange's assistance must be linguistically competent and take into consideration different levels of reading, English proficiency, and Internet skills.

Consumer-Focused Requirements. The exchange must:

1. create an Internet website on which individuals and small employers can compare costs and benefits of qualified health plans in a standardized format that meets federal requirements;

2. post on the website the relative quality and price rating information for qualified health plans developed by the U.S. Department of Health and Human Services (HHS);

3. inform consumers of enrollee satisfaction ratings for qualified health plans;

4. operate a toll-free consumer assistance hotline;

5. have available on the website a calculator that allows individuals to determine the actual cost of a qualified health plan, taking into consideration any applicable premium tax credit and cost-sharing reduction;

6. develop and provide consumer assistance that takes into consideration different levels of reading, English-proficiency, and Internet skills;

7. provide for initial, annual, and special enrollment periods;

8. determine if an applicant for health care coverage is eligible for Medicaid or the State Children's Health Insurance Program (SCHIP) and enroll eligible applicants in those programs;

9. enable an eligible person to apply for and enroll in a health benefit plan through the Internet, by mail or phone, or in person;

10. certify whether an individual is exempt from the PPACA's requirement to carry health insurance (e.g., the person has a qualifying religious exemption, is not in the United States lawfully, or is incarcerated); and

11. refer individuals to the healthcare advocate, where appropriate, or provide information about health benefit plan appeals.

Consumer Focus Groups. Before it begins operations, the exchange must use consumer focus groups to ensure its features, including its website, works for consumers, particularly low-income and special needs consumers.

Consumer Advisory Committee. The exchange must establish a standing consumer advisory committee to provide the directors with input on consumer-related matters.

Secret Shoppers. The exchange must develop ways to independently evaluate consumers' experiences with the exchange, including hiring secret shoppers.

Navigator Grant Program (§ 17)

The bill requires the exchange to establish a "navigator" grant program to award grants to certain entities to market the exchange. The exchange must establish performance standards, accountability requirements, and maximum grant amounts.

Purpose. A navigator must:

1. conduct public education activities about the availability of qualified health plans sold through the exchange;

2. distribute fair and impartial information about enrollment in qualified health plans and the availability of premium tax credits and cost-sharing reductions under the federal PPACA;

3. facilitate enrollment in qualified health plans;

4. refer individuals with a grievance, complaint, or question about

a plan, a plan's coverage, or a determination under a plan's coverage to the healthcare advocate or any customer relations unit the exchange establishes; and

5. provide information in a culturally and linguistically appropriate manner.

Entities Allowed as Navigators. The bill requires the exchange board to award navigator grants at the board's sole discretion to any of the following:

1. a trade, industry, or professional association;
2. a community and consumer-focused nonprofit group;
3. a chamber of commerce;
4. a labor union;
5. a small business development center; or
6. an insurance producer or broker licensed in Connecticut.

Under the bill, a navigator cannot (1) be an insurer or (2) receive any consideration directly or indirectly from an insurer for enrolling people in a qualified health plan.

To be considered for a navigator award, an entity must demonstrate to the board's satisfaction that it has, or could develop, relationships, with small employers, their employees, and individuals, including underinsured, uninsured, or self-insured individuals.

Miscellaneous. The bill requires a navigator to comply with the PPACA and related federal regulations and guidance and it requires the exchange to collaborate with HHS to develop standards that ensure the information navigators provide is fair and accurate.

Qualified Health Plans (§ 18)

The bill defines a "qualified health plan" as a health benefit plan certified as meeting criteria outlined in the PPACA and this bill.

Insurer Requirements. To be eligible to offer qualified health plans through the exchange, an insurer must be (1) approved by the exchange, (2) licensed in Connecticut, and (3) in good standing to offer health insurance in the state. The exchange must develop approval criteria and procedures. Any such criteria must comply with the PPACA and related federal regulations and guidance.

The exchange's criteria for an insurer wanting to offer individual qualified health plans must consider (1) the insurer's excess premium growth for plans offered outside the exchange as compared to the rate of premium growth for plans offered through the exchange and (2) information from other states about the insurer's premium growth rate. (The bill does not define "excess premium growth.")

The approval criteria must also require the insurer to:

1. if it offers plans both outside and through the exchange, offer the plans at the same premium rate;

2. offer through the exchange at least one plan at the silver coverage level (covering 70% of the cost of essential health benefits) and one plan at the gold coverage level (covering 80% of the cost of essential health benefits);

3. make available as a child-only policy each qualified health plan offered through the exchange;

4. meet marketing standards prescribed by the exchange or the PPACA and not use practices or benefit designs that discourage enrollment of people with significant health needs;

5. meet specified quality, quality improvement, and accreditation standards;

6. meet transparency standards, including disclosing information in plain language about claims, finances, enrollment, rating practices, out-of-network coverage cost sharing, enrollee rights under PPACA, and other information HHS requires;

7. receive, within the timeframe HHS sets, accreditation for local performance on clinical quality measures;

8. implement a quality improvement plan that provides incentives for improving enrollees' health outcomes, preventing hospital readmissions, improving patient safety, reducing medical errors, and implementing wellness and health promotion activities;

9. use a uniform, HHS-approved enrollment form;

10. use an HHS-developed standard format for presenting health benefit options;

11. provide enrollees and the exchange with information on quality measures for health plan performance as endorsed under federal law;

12. inform individuals, upon request, of the amount of cost-sharing (e.g., deductibles, copayments, and coinsurance) they are responsible for under their plans for specific services;

13. offer a dental-only plan if it covers pediatric dental benefits;

14. submit to the exchange and post on the insurer's website a justification for any premium increase before implementing the increase; and

15. comply with federal regulations relating to the exchange and any other requirements the exchange establishes.

Certification Requirements. Under the bill, the exchange cannot offer a health benefit plan unless it certifies that the plan meets federal, state, and exchange requirements. At a minimum, the certification criteria must require a qualified health plan to:

1. cover federally designated essential health benefits and state benefit mandates;

2. provide emergency department services without prior authorization or any coverage limit on out-of-network

emergency department service providers;

3. provide any out-of-network emergency department coverage under the same conditions as in-network cost sharing;

4. comply with any PPACA out-of-pocket cost limits and level of coverage requirements;

5. have an adequate number of providers in its network, including providers that serve predominantly low-income and medically underserved individuals, and provide individuals with information about the availability of in-network and out-of-network providers, where applicable; and

6. meet standards set by the exchange regarding premium rates and contract language.

Before certifying a health benefit plan, the exchange must determine that making the plan available is in the interests of individuals and small employers.

The exchange cannot exclude a plan (1) because it is a fee-for-service plan, (2) by imposing premium price controls, or (3) because it provides benefits to prevent an enrollee's death that are costly or inappropriate.

The exchange may certify a catastrophic plan only for individuals (1) under age 30 or (2) exempt from the PPACA's requirement to carry health insurance.

Exchange Transparency (§ 19)

The bill requires the exchange to promote transparency in its operations and administration by:

1. consulting with stakeholders on exchange requirements;

2. publishing on its website the average costs of licensing, regulatory fees, and any other payments required by the exchange and the exchange's administrative costs, including

funds lost to waste, fraud, and abuse;

3. keeping an accurate accounting of all activity receipts;

4. submitting to an annual HHS audit;

5. fully cooperating with any HHS investigation; and

6. ensuring that its funds are not spent for staff retreats, promotional giveaways, excessive executive compensation, or state or federal lobbying.

Premium Tax Credits and Cost-Sharing Reductions. The bill requires the exchange to coordinate with federal and state agencies and small employers to verify information relating to individuals' and small employers' eligibility for premium tax credits and cost-sharing reductions.

The exchange must give the U.S. Treasury secretary a list of:

1. individuals exempt from the PPACA's requirement to carry health insurance, including their Social Security numbers;

2. individuals employed but eligible for the premium tax credit because the individual's employer did not provide minimum essential coverage, the individual could not afford such employer's health benefit plan, or the employer did not provide at least a bronze level of coverage;

3. the name and Social Security number of each employee who notifies the exchange that he or she has changed employers; and

4. the name of each individual who ceases coverage under a qualified health plan during a plan year and the cessation's effective date.

The exchange must provide (1) each employer the name of each employee who qualified for a premium tax credit and (2) HHS information on all exchange applicants to verify eligibility. The information provided to HHS must include:

1. the applicants' names, birth dates, and citizenship statuses;

2. for applicants seeking a premium tax credit or cost-sharing reduction, their incomes, family sizes, full-time employment status, and reasons for not being covered by an employer-sponsored health benefit plan; and

3. for applicants seeking an exemption from the PPACA's requirement to carry health insurance, information supporting the exemption request.

If HHS notifies the exchange that the information the applicant provided is inconsistent, the exchange must make a reasonable effort to identify and address the causes of the inconsistency.

Application Decisions and Notifications. The exchange must, within 90 days after receiving an application, determine (1) the applicant's eligibility for a premium tax credit and cost-sharing reduction, (2) the affordability of the applicant's employer's health benefit plan, and (3) the applicant's eligibility for an exemption from the PPACA's requirement to carry health insurance.

If an application contains an unresolved inconsistency concerning a premium tax credit or cost-sharing reduction after the initial 90-day period, the exchange must notify the applicant of the (1) amount, if any, of a premium tax credit or cost-sharing reduction available to him or her based on information provided by HHS and (2) available appeals procedures.

If an application contains an inconsistency concerning an individual seeking an exemption from the PPACA requirement to carry health insurance, the exchange must, within 90 days after receiving notification from HHS, notify the applicant (1) that the exchange will not issue a certification of exemption and (2) of available appeals procedures.

If HHS informs the exchange that an employer may be liable for assessments under the Internal Revenue Code because the employer

failed to provide affordable or minimum essential coverage through an employer-sponsored plan, the exchange must notify the employer and provide information about available appeals procedures.

§§ 1-10 – CONFORMING CHANGES TO COMPLY WITH PPACA

Dependents to Age 26 (§§ 1-4)

Under the federal PPACA, children may stay on a parent's health insurance plan until age 26. The bill revises various insurance statutes to comply with this requirement. Current state law restricts a child's coverage based on his or her marriage or residency status.

Preexisting Conditions (§§ 5-7)

Under the federal PPACA, insurers cannot impose a preexisting condition limitation that excludes coverage for children under age 19. The bill revises various insurance statutes to comply with this requirement.

The bill makes various definitions of preexisting conditions provision consistent throughout the insurance statutes. It defines a preexisting condition as a condition, whether physical or mental, for which medical advice, diagnosis, or care or treatment was previously recommended or received during a specified period. For individual and group health insurance policies, that period is the six months immediately preceding the effective date of coverage.

Comprehensive Health Care Plans (§ 6)

Lifetime Limits. Under the federal PPACA, health benefit plans cannot impose lifetime limits on the dollar value of essential health benefits, to be defined by HHS. To conform to the federal requirement, the bill prohibits individual and group comprehensive health care plans from imposing such a lifetime limit. It specifies that a plan may include a lifetime limit of at least $1 million on benefits that are not essential health care benefits as defined by PPACA and related regulations.

Mental Health Benefits. The bill eliminates specific provisions that allow mental health benefits to vary from benefits for physical

conditions. Thus, it requires comprehensive health care plans to provide mental health benefits on the same terms as physical benefits.

Pregnancy. The bill removes a provision that requires comprehensive health care plans to limit pregnancy benefits to $250. Thus, it requires the plans to cover pregnancy on the same basis as other conditions.

Rescissions (§§ 8 and 9)

The federal PPACA limits policy rescissions (e.g., retrospective policy cancellations) to instances of fraud and intentional material misrepresentation.

Under state law, an insurer or HMO must obtain the insurance commissioner's approval for a policy rescission, cancellation, or limitation. The bill requires the commissioner to approve a request for rescission or limitation when the insured or the insured's representative (1) submitted fraudulent (rather than false) information on an insurance application, (2) intentionally (rather than knowingly) misrepresented material information on the application, or (3) intentionally (rather than knowingly) omitted material information from the application. He must approve a cancellation in accordance with federal law, which requires prior notification to the insured.

Medical Loss Ratio (§ 10)

The Insurance Department publishes an annual Consumer Report Card on Health Insurance Carriers in Connecticut. By law, the report card must include each insurer's and HMO's medical loss ratio. The bill specifies that "medical loss ratio" has the meaning provided in the federal PPACA.

"Medical loss ratio" is generally the percentage of premium dollars that an insurer or HMO spends on providing health care and health care quality improvement activities, versus how much is spent on administrative and overhead costs.

BACKGROUND

Related Bills

The Insurance and Real Estate Committee reported out SB 921, which similarly creates an exchange as a quasi-public agency. The committee also reported out sSB 1158, which contains the same rescission provisions as this bill.

The Public Health Committee reported out sSB 1204, which similarly creates an exchange as a quasi-public agency.

COMMITTEE ACTION

Insurance and Real Estate Committee

Joint Favorable Change of Reference
Yea 14 Nay 3 (03/10/2011)

Government Administration and Elections Committee

Joint Favorable Change of Reference
Yea 10 Nay 4 (03/23/2011)

Finance, Revenue and Bonding Committee

Joint Favorable
Yea 34 Nay 18 (04/07/2011)